BEFORE THE
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MOUANG SAETURN 442 San Rafael Street Fairfield, CA 94533 Psychiatric Nurse License No. PT 31730 Respondent.	Case No. PT-2005-752 OAH No. 2008020665

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Vocational Nursing and Psychiatric Technicians as the final Decision in the above-entitled matter.

This Decision shall become effective on May 31, 2009.

IT IS SO ORDERED this 1st day of May, 2009.

John P. Vertido, L.V.N
President

BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MOUANG SAETURN Psychiatric Technician License No. PT 31730 Respondent.	Case No. PT-2005-752 OAH No. 2008020665

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings, on February 25, 2009, in Sacramento, California.

Geoffrey S. Allen, Deputy Attorney General, appeared on behalf of complainant.

Edward O. Lear, Esq., appeared on behalf of Mouang Saeturn, who was also present.

The case was submitted for decision on February 25, 2009.

FACTUAL FINDINGS

1. Teresa Bello-Jones, J.D., M.S.N., R.N., (complainant) is the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs. She made and brought the accusation solely in her official capacity.

2. On May 28, 2003, the Board issued Psychiatric Technician License Number PT 31730 to Mouang Saeturn (respondent). The license expired on August 31, 2008, unless renewed.

3. Complainant contends that respondent's license should be disciplined because she engaged in unprofessional conduct, specifically for failing to perform required patient bed checks every half hour, and signing an activity log verifying that patient bed checks had been made every half hour when, in fact, they had not. Respondent does not dispute the basic facts alleged in the accusation, but contends that the Board must consider the context in which events underlying this disciplinary action unfolded in determining what discipline should be imposed.

4. Respondent was employed since January 2003, as a psychiatric technician at Napa State Hospital (NSH), a California Department of Mental Health Facility. She worked the graveyard shift from 2300 to 0700 hours. This shift was referred to as the "NOC shift." She was assigned to the Q3&4 unit at NSH, which provided mental health services for forensic individuals, and for non-forensic individuals who are under conservatorship and require a secure treatment setting. These individuals are sometimes referred to as "Penal Code patients" because they are referred to NSH by courts for treatment, and have been diagnosed with mental illness, insanity, or are on drugs. Q3&4 is one of the most violent wards at NSH. It is a locked facility, where up to 65 male patients receive psychiatric services. Respondent described it as "essentially a prison." NSH refers to its residents and patients as "clients."

5. It is the policy of NSH to monitor and/or observe all clients on a regular basis in order to insure their safety and wellbeing. NSH issued Administrative Directive No. 676, effective July 24, 2003, that detailed client monitoring protocols. It provided: "After clients go to bed at night, rounds of all sleeping areas shall be made a minimum of once in every clock half hour and the condition of each client observed. Rounds shall be documented on the noc shift client activity log ... The time of each round shall be indicated."

NSH used an activity log form that allowed entries for each client from 2300 to 0600 hours, with columns for each half hour. There was a space for monitoring staff to initial column entries, and a line on the bottom for the signature of the "Shift Lead." Monitoring staff were to use codes to describe the status of each client when observed.[1] Additional written instructions were attached to the activity log. These instructions for unit rounds specified:

> 1. Rounds must occur, on a random basis, a minimum of once in each clock half hour starting with the time the client retires.
>
> 2. Rounds that occur prior to 2300 or after 0630 are to be noted in the day log.

[1] NSH used letters A through H for coding. For example, A meant "Up and active/out of room" and B meant "In bed, eyes shut, breathing."

3. When completing rounds, use the coding as indicated at the bottom of the form.

4. When checking clients always make sure each client is breathing.

5. Staff completing rounds are to initial each column at the bottom as an indication that all clients in column checked during that clock half hour.

6. Staff are to initial and sign on the back of the form to identify staff initials for each round.

7. Indicate unit number at the top of the form.

8. Unit Rounds are to be signed by the shift lead on the front of the form, reviewed by Unit Supervisor on the back of the form and attached to the daily log.

Incident

6. Respondent worked the NOC shift from 2300 to 0700 hours on the evening of March 20 and 21, 2005. She was the Acting Shift Lead, responsible for staffing, unit security and overall completion of work. This included undertaking a daily audit of all client charts to insure that medication and treatment orders were completed. She worked with four other staff members including Helen Masilang, R.N., Lupe Mendez, R.N., Girlie Padaoan, P.T.A.[2] and Angelina Sabaria, P.T.A. Ms. Sabaria was assigned 1:1 responsibility for a client, and was therefore unavailable to perform unit rounds unless she was relieved of client responsibility. This meant that only four staff, including respondent, were available to do rounds at any given time. There were 63 clients in the Q3&4 unit the evening of March 20 and 21, 2005. Rounds are typically performed by two staff. It takes approximately 25 minutes to do rounds for 65 beds.

7. On the evening of March 20 and 21, 2005, physical rounds on the Q3&4 unit were performed by staff at 2300, 0100, 0300 and 0500 hours.

8. On March 21, 2005, at approximately 0120 hours, Client A was found hanging from the ceiling in a bathroom that had been believed to be locked earlier. He had tied together two shoelaces and secured them to a metal grill over a toilet. He was taken to a local acute care hospital where he was pronounced dead. Client A had been observed at the beginning of the NOC shift, around midnight. There were no rounds between then and 0100. During the 0100 rounds Client A was reported

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[2] Psychiatric Technician Assistant.

missing, and the ensuing search found him in the bathroom, door locked. Lupe Mendez cut him down and CPR efforts were commenced.

Standard of Care – Bed Checks

9. Linda C. Bailey testified as an expert witness on behalf of complainant. She is a registered nurse. She has worked as a nursing consultant for 15 years. She retired in 2001 from a coordinator of nursing services position at Porterville Developmental Center, where she was responsible for the overall quality of nursing practice, nursing policy, protocols and procedures. Ms. Bailey was responsible for coordination of nursing service staffing, including for psychiatric technicians. While at Porterville Developmental Center, she served in other positions including medical services program manager, nursing education director and health services specialist. She also worked as director of nursing and director of nursing services at Lindsay District Hospital. Ms. Bailey taught both nursing and psychiatric technician courses at Porterville Developmental Center. She continues to consult and teach at the community college level, including West Hills Community College where she serves as adjunct to the Director of the Psychiatric Technician Program. Between 1964 and 1973, Ms. Bailey worked as a psychiatric technician at Porterville Developmental Center.[3]

10. Ms. Bailey opined that the standard of care for the monitoring of individuals with mental disorders is to do so every half hour. It is a standard driven by the level of care necessary for these particular individuals. She noted: "The standard of practice for a competent licensed Psychiatric Technician in this situation is to always make bed checks in pairs and every thirty minutes throughout the night." Ms. Bailey explained that this is a safety issue, "to ensure clients and staff alike are always safe." This was the standard that was incorporated into the NSH administrative directive and the policy governing client monitoring protocols on the NOC shift. The clients in the Q3&4 unit fell within the class of individuals with mental disorders who required this level and frequency of monitoring.

Ms. Bailey opined that it is also the standard of practice to ensure that all clients are breathing when doing bed checks throughout the night. The NSH policy was to do so and the NSH activity log form used for documenting unit rounds contained this instruction: "When checking clients always make sure each client is breathing."

11. Based upon Finding 7, it was established that respondent, as the acting shift lead, failed to perform the required patient bed checks every half hour.

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[3] It was then known as Porterville State Hospital.

12. Respondent acknowledges that the required bed checks were not performed on the half hour. On that particular evening, only four staff were available to perform bed checks at any given time because the fifth staff member was assigned 1:1 client responsibility. Because rounds took nearly a half hour to complete, performing them on the half hour would have required that two staff be dedicated to doing rounds during the entire shift. One of respondent's major responsibilities was to audit client charts during the NOC shift. This entailed going through every chart to ensure that all medications and treatment orders had been completed during the day. This consumed a substantial amount of respondent's time.

Mr. Mendez has worked at NSH for approximately 20 years. He is a registered nurse and had worked as the shift lead in the Q3&4 psychiatric unit. He noted that performing rounds every half hour for that unit was just not possible. Staff members were aware of the half hour bed check policy. However, Mr. Mendez noted that they were also trained to deviate from this policy when necessary to maintain the safety of the unit.

13. On the evening of March 20 and 21, 2005, staff were primarily concerned and occupied with a Client B who had a history of assaulting peers and threatening staff. He weighed over 260 pounds, and was pacing around the nursing station exhibiting menacing and aggressive behaviors. It was not safe for a single staff member to confront him, so respondent, Mr. Mendez and Ms. Masilang worked as a team to de-escalate the situation. Mr. Mendez noted that it could take hours to calm Client B down. Respondent determined that this situation warranted the early and continued attention of staff. Team rounds were therefore performed only on two-hour intervals at 2300, 0100, 0300 and 0500 hours. Performing rounds at intervals greater than a half hour was a common and accepted practice on the Q3&4 NOC shift whenever staff were occupied with more immediate client safety issues.

Ms. Bailey acknowledged that in a situation where a shift lead was faced with a hostile client engaging in assaultive behavior, and who had a history of violence, it was appropriate to have several staff members engaged in de-escalating the situation, and to deviate from the bed check policy. Ms. Bailey noted, however, that the lone staff member at the desk should have called for help to maintain care and responsibility for the balance of clients.

14. Respondent's failure to insure that bed checks were performed on the half hour on the evening of March 20 and 21, 2005, departed from the standard of care. However, such departure, given the circumstances that evening, was not substantial. A competent licensed psychiatric technician under similar circumstances would have deviated from the normal bed check policy to attend to the more immediate threat of violence posed by Client B. For these reasons, respondent's failure to perform required bed checks every half hour that evening did not constitute unprofessional conduct.

Separate accusation allegations relating to failures to make the required bed checks while paired with another person, or to ensure that the patients were breathing when performing the required be checks, are not at issue. When bed checks were performed, these protocols were followed.

Dishonest Act

15. The NSH client activity log form completed for the evening of March 20 and 21, 2005, documented that bed checks were performed on the half hour for all 63 clients in the Q3&4 unit that evening. Entries for each half hour were initialed by staff members who purportedly performed the bed check. Respondent signed the client activity log as the shift lead. Respondent knew that bed checks had not occurred on the half hour as documented at the time she signed off on the activity log as shift lead. Her doing so was an act involving dishonesty, and constituted unprofessional conduct.

16. The above matter was egregious not only because bed checks had not occurred when indicated, but because staff were routinely fabricating client information about bed checks that had not occurred. It was one thing to say that a bed check had occurred when it had not. It was quite another to say that a bed check had occurred and that the client was "up and active/out of room," "in bed, eyes shut, breathing," or "up and active in room" per the coding used on the client activity log form. Staff entered codes for such client activities for bed checks that had never occurred. Respondent was aware of this practice. It had not occurred on this occasion only. It was apparently a regular practice at NSH. And it was the worst kind of charting imaginable because it was all imagined. It was clearly dishonest.

17. Respondent acknowledges that her signing off on the client activity log was poor practice. She now understands that her doing so was unacceptable and misleading. She noted that she was trained better than that at her psychiatric technician school. She takes her responsibility to chart accurately more seriously now. As she thinks back, she wishes she had said something about this NSH practice sooner. Respondent describes her present approach to work as "very cautious and detail oriented."

Matters considered in mitigation include the fact that having staff sign off on rounds that had not occurred was indeed common NSH charting practice. NSH now uses a different form that allows staff to document why it was not possible to do rounds on the half hour. Also considered is that in May 2005, respondent was a relatively new psychiatric technician. It is more difficult for a new licensee to speak out against poor institutional practices than a more experienced psychiatric technician. Importantly, during the investigation of Client A's death, respondent stated that rounds were performed at 0100, 0300 and 0500 hours. She answered all questions honestly and did not attempt to mislead investigators on the number or frequency of monitoring that evening. Her signing off on the activity log was not part

of a larger plan to mislead. Rather, it was indicative of the lax and careless approach that was taken by respondent and others at NSH to documenting bed checks that had not occurred.

Other Matters

18. Respondent now works as a registered nurse in an intensive care unit (ICU) at Kaiser Hospital Vallejo. She submitted 12 reference letters attesting to her reputation as a competent and skilled nurse. For example, Christopher Raras is a registered nurse who works with her at Kaiser Vallejo ICU. He indicated that he is aware of the allegations and accusations against her, and fully supports her continued licensure as a psychiatric technician and registered nurse. He noted: "I have always found Mouang to be a very dependable, hard working, and honest individual who always maintains her professionalism. She focuses on providing her best patient care through her awareness of patient and staff safety as well as through her patient advocacy. Mouang possesses valuable communication skills, team-working abilities, and overall a good sense of judgment in how to handle any situation she may be faced with."

Similarly, Eric J. Kamoloni is a registered nurse who works with respondent at Kaiser Vallejo. He is aware of the allegations that were brought against her. Mr. Kamoloni wrote: "It is with whole-heartedness that I convey that Ms. Saeturn is a woman of integrity and self-discipline. I know she would not willfully bring malice to any patient within the spectrum of her care. I implore you to consider Ms. Saeturn's track record to date and you will see that her level of nursing skills relating to patient care is impeccable."

19. Respondent has learned from the events of March 20 and 21, 2005. She understands that a NSH shift lead should not "go with the flow" and that she should have stepped up and said that the charting practices there were wrong. She agrees that her actions were both unacceptable and misleading. She takes her responsibility as a nurse, and this presumably includes charting, much more seriously as a result of this case. Respondent understands the importance of honesty and accuracy in charting and she is now much more cautious and detail-oriented as a registered nurse at Vallejo Kaiser ICU. There was no evidence of any other disciplinary action or complaints relating to her nursing practice since the matters complained of in this Accusation. For all these reasons it would not be contrary to the public interest for respondent's psychiatric technician license to be placed on probation at this time.

20. Respondent is concerned that one of the Board's standard terms of probation is that she work in her licensed capacity as a psychiatric technician over any period of probation. Her full time work as a Kaiser ICU nurse would conflict with this requirement. For purposes of probation, the Board should consider respondent's work as a registered nurse in Kaiser ICU as equivalent time to satisfy the requirement

for "work in her licensed capacity." Because there is considerable overlap of knowledge, skill and experience between these two nursing professions, such is not unreasonable. In this case, the area of primary concern is charting, and respondent's work in Kaiser ICU provides ample opportunity to monitor charting activities. The degree and scope of charting as a registered nurse is at least as comprehensive as that required of psychiatric technicians. The only alternative would be to toll any probationary period until such time as respondent returned to full time work as a psychiatric technician. Given the uncertainty and perhaps unlikelihood of this event, it makes more sense to monitor respondent now, using her full time work as a registered nurse as equivalent time for purposes of Board probation.

Cost Recovery

21. The Board has incurred the following costs in connection with its investigation and prosecution of this case:

Attorney General's Costs:

(FY 2007-08)	8.50 hrs (Attorney)	@ $158	$1,343.00
(FY 2007-08)	10.00 hrs (Paralegal)	@ $101	1,010.00
(FY 2008-09)	30.50 hrs (Attorney)	@ $158	4,819.00

Total Attorney General's Costs: $7,172.00

The Board is entitled to recover a total of $7,172.00 as its reasonable costs in connection with its investigation and prosecution of this case.

LEGAL CONCLUSIONS

1. Business and Professions Code section 4521 provides:

The board may suspend or revoke a license issued under this chapter [the Psychiatric Technicians Law] for any of the following reasons:

(a) Unprofessional conduct, which includes but is not limited to any of the following:

(1) Incompetence or gross negligence in carrying out usual psychiatric functions.

[¶] ... [¶]

(n) The commission of any act involving dishonesty, when that action is substantially related to the duties and functions of the licensee.

2. Respondent's failure to perform required bed checks every half hour on the evening of March 20 and 21, 2005, did not constitute unprofessional conduct. Circumstances arose that evening that made deviation from the standard practice of half hour bed checks appropriate. (See Findings 12 through 14.) It was not a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician. (Cal. Code Regs., tit. 16, § 2577.) Therefore, no cause for disciplinary action exists under Business and Professions Code section 4521, subdivision (a)(1).

3. Cause for disciplinary action exists under Business and Professions Code section 4521, subdivision (n), by reason of the matters set forth in Findings 15 and 16. Respondent committed an act involving dishonesty, and because it related to charting it was substantially related to the duties and functions of a psychiatric technician. Such constitutes unprofessional conduct.

4. The matters set forth in Findings 17 through 20 have been considered. Respondent has accepted responsibility for, and has made changes in her approach to nursing as a result of the events of March 20 and 21, 2005. She understands that her actions were unacceptable and misleading, and realizes the importance of honesty and accuracy in charting. There was no evidence of any other disciplinary action or complaints relating to her nursing practice since this incident. She is presently working as a registered nurse with Kaiser Vallejo ICU. As earlier noted, it would not be contrary to the public interest for respondent's psychiatric technician license to be placed on probation with the Board at this time. However, the standard term of probation regarding work in her "licensed capacity" should allow equivalent time and credit for her work as a registered nurse.

5. Under Business and Professions Code section 125.3, the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. The reasonable costs in this case total $7,172.00. (Finding 21.)

ORDER

Psychiatric Technician License Number PT 31730 issued by the Board to Mouang Saeturn, is revoked pursuant to Legal Conclusion 3. However, the revocation is stayed and respondent is placed on probation for three (3) years under the following terms and conditions:

1. Obey All Laws. Respondent shall obey all federal, state and local laws, including all statutes and regulations governing the license. Respondent shall submit, in writing, a full and detailed account of any and all violations of the law, including alleged violations, to the Board within five (5) days of occurrence.

To ensure compliance with this condition, respondent shall submit fingerprints through the Department of Justice and Federal Bureau of Investigation within thirty (30) days of the effective date of the decision, unless the Board determines that fingerprints were previously submitted by the respondent to the Board.

Respondent shall also submit to the Board a recent 2" x 2" photograph of himself/herself within thirty (30) days of the effective date of the decision.

If respondent is under a criminal court order, including probation or parole, and the order is violated, it shall be deemed a violation of these probation conditions.

2. Compliance With Probation Program. Respondent shall fully comply with the conditions of probation established by the Board and shall cooperate with representatives of the Board in its monitoring and investigation of respondent's compliance with the Probation Program.

Upon successful completion of probation, respondent's license will be fully restored.

3. Submit Written Reports. Respondent shall submit or cause to be submitted, under penalty of perjury, any written reports, declarations and verification of actions as required by the Board or its representatives. These reports or declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

In the first report, respondent shall provide a list of all states and territories where she has ever been licensed as a vocational/practical nurse, psychiatric technician, or registered nurse. Respondent shall provide information regarding the status of each license and any change in license status during the period of probation. Respondent shall inform the Board if she applies for or obtains a new nursing or psychiatric technician license during the period of probation.

Respondent shall provide a copy of the Board's decision to the regulatory agency in every state and territory in which she has applied for or holds a vocational/practical nurse, psychiatric technician and/or registered nurse license.

4. Notification of Address and Telephone Number Changes. Respondent shall notify the Board, in writing, within five (5) days of any change in address or telephone number(s).

Respondent's failure to claim mail sent by the Board may be deemed a violation of these probation conditions.

5. Notification of Residency or Practice Outside of State. Respondent shall notify the Board, in writing, within five (5) days, if she leaves California to reside or practice in another state. Periods of residency or practice outside of California shall not apply toward a reduction of this probation time period. If respondent resides or practices outside of California, the period of probation shall be automatically extended for the same time period she resides or practices outside of California. Respondent shall provide written notice to the Board within five (5) days of any change of residency or practice.

Respondent shall notify the Board, in writing, within five (5) days, upon her return to California.

6. Meetings With Board Representatives. Respondent shall appear in person at meetings as directed by the Board or its designated representatives.

7. Notification To Employer(s). When currently employed or applying for employment in any capacity in any health care profession, respondent shall notify her employer of the probationary status of respondent's license. This notification to respondent's current health care employer shall occur no later than the effective date of the Decision. Respondent shall notify any prospective health care employer of her probationary status with the Board prior to accepting such employment. At a minimum, this notification shall be accomplished by providing the employer or prospective employer with a copy of the Board's Accusation and Disciplinary Decision.

The Health Care Profession includes, but is not limited to: Licensed Vocational Nurse, Psychiatric Technician, Registered Nurse, Medical Assistant, Paramedic, Emergency Medical Technician, Certified Nursing Assistant, Home Health Aide, and all other ancillary technical health care positions.

Respondent shall cause each health care employer to submit to the Board all performance evaluations and any other employment related reports as required by the Board. Respondent shall notify the Board, in writing, of any difficulty in securing employer reports within five (5) days of such an event.

Respondent shall notify the Board, in writing, within five (5) days of any change in employment status. Respondent shall notify the Board, in writing, if she is terminated or separated, regardless of cause, from any nursing or health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. Employment Requirements and Limitations. Respondent shall work in her licensed capacity as a psychiatric technician or as a registered nurse in the state of California. This practice shall consist of no less than six (6) continuous months and of no less than twenty (20) hours per week.

Respondent shall not work for a nurses' registry or in any private duty position, a temporary nurse placement agency, as a faculty member in an accredited or approved school of nursing, or as an instructor in a Board approved continuing education course except as approved, in writing, by the Board. Respondent shall work only on a regularly assigned, identified and predetermined work site(s) and shall not work in a float capacity except as approved, in writing, by the Board.

9. Supervision Requirements. Before commencing or continuing employment in any health care profession, respondent shall obtain approval from the Board of the supervision provided to respondent while employed.

Respondent shall not function as a charge nurse (i.e., work in any healthcare setting as the person who oversees or directs licensed vocational nurses, psychiatric technicians, certified nursing assistants or unlicensed assistive personnel) or supervising psychiatric technician during the period of probation except as approved, in writing, by the Board.

10. Completion of Educational Courses. Respondent, at her own expense, shall enroll and successfully complete a course(s) substantially related to the violation(s) no later than the end of the first year of probation.

The coursework shall be in addition to that required for license renewal. The Board shall notify respondent of the course content and number of contact hours required. Within thirty (30) days of the Board's written notification of assigned coursework, respondent shall submit a written plan to comply with this requirement. The Board shall approve such plan prior to enrollment in any course of study.

Upon successful completion of the course, respondent shall submit "original" completion certificates to the Board within thirty (30) days of course completion.

11. Maintenance of Valid License. Respondent shall, at all times, maintain an active current license with the Board including any period of suspension.

If an initial license must be issued (Statement of Issues) or a license is reinstated, probation shall not commence until a license is issued by the Board. Respondent must complete the licensure process within two (2) years from the effective date of the Board's decision.

Should respondent's license expire, by operation of law or otherwise, upon renewal or reinstatement, respondent's license shall be subject to any and all conditions of this probation not previously satisfied.

12. Cost Recovery Requirements. Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $7,172.00.

Respondent shall be permitted to pay these costs in a payment plan approved by the Board with payments to be completed no later than three months prior to the end of the probation period. The filing of bankruptcy by respondent shall not relieve respondent of his/her responsibility to reimburse the Board for its investigation and prosecution costs. Failure to make payments in accordance with any formal agreement entered into with the Board or pursuant to any Decision by the Board shall be considered a violation of probation.

If respondent has not complied with this condition during the probationary period, and respondent presents sufficient documentation of her good faith effort to comply with this condition, and if no other conditions have been violated, the Board or its representatives may, upon written request from respondent, extend the probation period up to one year, without further hearing, in order to comply with this condition. During the extension, all original conditions of probation will apply.

Except as provided above, the Board shall not renew or reinstate the license of any respondent who has failed to pay all the costs as directed in a Decision.

13. License Surrender. During probation, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the conditions of probation, respondent may surrender her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request without further hearing. Upon

formal acceptance of the tendered license, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the Board. A licensee who surrenders her license may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision for the surrender:

- Three (3) years for reinstatement of a license surrendered for any reason other than a mental or physical illness; or
- One (1) year for a license surrendered for a mental or physical illness.

14. Violation of Probation. If respondent violates the conditions of her probation, the Board, after giving respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of respondent's license. If during probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

DATED: March 10, 2009

JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MOUANG SAETURN** 442 San Rafael Street Fairfield, CA 94533 Psychiatric Technician's License No. PT 31730 Respondent.	Case No. PT-2005-752 **ACCUSATION**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians ("Board"), Department of Consumer Affairs.

2. On or about May 28, 2003, the Board issued Psychiatric Technician License No. PT 31730 to Mouang Saeturn ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2008.

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STATUTORY & REGULATORY PROVISIONS

3. Section 4520 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensed psychiatric technician for any reason provided in Article 3 (commencing with Code section 4520) of the Psychiatric Technicians Law (Code section 4500, et. seq.)

4. Code section 118, subdivision (b) provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under Code section 4545, the Board may renew an expired license at any time within four years after the expiration.

5. Code section 4521 states, in pertinent part:

> The board may suspend or revoke a license issued under this chapter for any of the following reasons:
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> . . . .
>
> (a) Unprofessional conduct, which includes, but is not limited to, any of the following:
>
> (1) Incompetence or gross negligence in carrying out usual psychiatric technician functions.
>
> . . . .
>
> (n) The commission of any act involving dishonesty, when that action is substantially related to the duties and functions of the licensee. . .

6. California Code of Regulations, title 16, section ("Regulation") 2577 states:

> As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care.

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COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. At all times herein mentioned, Respondent was employed as a psychiatric technician with the assignment of Acting Shift Lead in the Q3&4 unit[1] at Napa State Hospital ("NSH"), a California Department of Mental Health facility, in Napa, California. Respondent was on duty during the NOC shift from 2300 hours on March 20, 2005, through 0700 hours on March 21, 2005.

9. On or about March 21, 2005, at approximately 0120 hours, Patient A, 36 years of age, who had a history of suicide ideation and was assessed as being at a moderate risk for suicide, was found hanging from the ceiling in a bathroom that had been believed to be locked earlier.

10. Respondent is subject to disciplinary action pursuant to Code section 4521, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about March 21, 2005, while on duty as a psychiatric technician with the assignment of Acting Shift Lead in the Q 3&4 unit of NSH, Respondent was guilty of gross negligence, within the meaning of Regulation 2577, as follows:

a. Respondent failed to perform the required patient bed checks every half hour. Further, Respondent signed the NOC Activity Log verifying that patient bed checks had been made every half hour when, in fact, they had not.

b. Respondent failed to make the required bed checks while paired with another person.

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1. The Q 3&4 unit at NSH provides mental health services for forensic individuals, and for non-forensic individuals who are under conservatorship and require a secure treatment setting.

c. Respondent failed to ensure that the patients were breathing when performing the required bed checks.

SECOND CAUSE FOR DISCIPLINE

(Dishonest Act)

11. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraph 7 above.

12. Respondent is subject to disciplinary action pursuant to Code section 4521, subdivision (n), in that she committed the following act involving dishonesty relating to the duties and functions of a psychiatric technician: On or about March 21, 2005, Respondent signed the NOC Activity Log verifying that patient bed checks had been made every half hour when, in fact, they had not, as set forth in paragraph 9(a) above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action pursuant to Code section 4521, subdivision (a), in that on or about March 21, 2005, while on duty as a psychiatric technician in the Q 3&4 unit at NSH, Respondent committed acts constituting unprofessional conduct, as set forth in paragraphs 9 and 12 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Psychiatric Technician License No. PT 31730, issued to Mouang Saeturn;

2. Ordering Mouang Saeturn to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

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3. Taking such other and further action as deemed necessary and proper.

DATED: January 15, 2008

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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